ATTACHMENT C

Implementation Questionnaire
For State Pharmaceutical Assistance Program (SPAP)

Data Sharing Agreement

Version 9/19/05

SPAP Data Sharing Agreement Implementation Questionnaire

SPAP Name: _____

Date: _____

Please check all that apply:

I. SPAP Specific Information

☐ SPAP offers a network prescription drug benefit.

☐ SPAP offers a network prescription drug benefit and shall provide its Rx BIN and/or PCN below. (If you have more than one BIN/PCN, please submit all of these numbers to the CMS in a separate attached Word document).

Rx BIN _____
PCN _____

☐ SPAP offers a network prescription drug benefit and shall provide its TrOOP Rx BIN and/or PCN below. (If you have more than one TrOOP BIN/PCN, please submit all of these numbers to the CMS in a separate attached Word document).

TrOOP Rx BIN _____
TrOOP PCN _____

II. Questions regarding how SPAP will submit prescription drug coverage of its SPAP Enrollees:

☐ SPAP will satisfy its Data Sharing Agreement requirement to submit prescription drug coverage of its SPAP Enrollees using the Input file of the SPAP Data Sharing Agreement.

☐ SPAP contracts with a Pharmacy Benefit Manager (PBM) to pay prescription drug benefits in the pharmacy network. Please provide the name of the PBM _____.

☐ SPAP's PBM, named above, has (1) signed a Data Sharing Agreement with CMS and (2) signed an agreement with the SPAP stating they will satisfy the SPAP's Data Sharing Agreement requirement to submit prescription drug coverage of its SPAP Enrollees.